MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1757 — Reg. Dist. No. 01761

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M d. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R.D.3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Rufus — Middle — Last Anthony

4. DATE OF DEATH: Month Feb. — Day 26 — Year 1959

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr.1,1904
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Anthony
14. MOTHER'S MAIDEN NAME: Cecilia-?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Banks Whitaker-R.D.3 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral suppurative bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: about 10 days
491 X
DUE TO: with gangrene of lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): duodenum.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
Bleeding gastric ulcer and ulcer of diverticulum of

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1959, to Feb. 26, 1959, that I last saw the deceased alive on Feb. 26, 19 69, and that death occurred at 8:20a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street
DATE SIGNED: 2/26/59

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/2/59
22c. NAME OF CEMETERY OR CREMATORY: Griffin Cem.
22d. LOCATION (City, town, or county) (State): Cedar Hill. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edw. R. Bell — ADDRESS: 909 Poplar St., Wilm. Del.
24a. REC'D BY REGISTRAR DATE: MAR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted] registrar director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1772

CERTIFICATE OF DEATH

01762
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Md
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hilda — Middle: M. — Last: Betker

4. DATE OF DEATH: Month: 2 — Day: 21 — Year: 19 59

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-11-1904
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E.Goodnow
14. MOTHER'S MAIDEN NAME: Ethel W.Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: George F.Betker North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 years
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Essential Hypertension.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 Nov, 1958, to 21 Feb, 1959, that I last saw the deceased alive on 8th Feb, 1959, and that death occurred at 9.40 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): No. 44 E. 7th Pl — DATE SIGNED: 23 Feb 59

PHYSICIAN'S NAME (Type): Klaus H. Huebner (M.D.)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-25-1959
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county) (State): North East, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 26 '59
24b. REGISTRAR'S SIGNATURE: Carling L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1758 — Reg. Dist. No. 01763

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Devine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen R.F.D. #2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AMANDA — Middle — Last BOYLE

4. DATE OF DEATH: Month Feb. — Day 6 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 13, 1875

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edwin Hill

14. MOTHER'S MAIDEN NAME: Mary Krauss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ralph E Andrews Address 123 So. Broad St. Phila. 9, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiac Marked disease with
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b) DUE TO: Hypertensive and Cardiac Hypertrophy
(c)

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 28, 19 59, to Feb. 6, 19 59, that I last saw the deceased alive on Feb 6, 19 59, and that death occurred at 6:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Andrews Jr M.D.
ADDRESS (Street, city or town, state): 233 E Main St.
DATE SIGNED: 2/6/59
PHYSICIAN'S NAME (Type): R. RALPH ANDREWS, JR. ELKTON, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/1959
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
22d. LOCATION (City, town, or county) (State): Colora Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Earl Tipton
ADDRESS: RisingSun, Md.

24a. REC'D BY REGISTRAR DATE: FEB 10 '59
24b. REGISTRAR'S SIGNATURE: Cecilia L. Knapp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1773 CERTIFICATE OF DEATH

01764
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East, Rural
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East, Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Edmund — Last: Crothers

4. DATE OF DEATH: Month: February — Day: 9 — Year: 1959

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: October 27, 1867

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James C. Crothers

14. MOTHER'S MAIDEN NAME: Hannah Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-12-4548

INFORMANT: Mr. Charles T. Crothers, Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-6-1959, 19___, to 2-5-59, 19___, that I last saw the deceased alive on 2-6-59, 19___, and that death occurred at 4 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md. — DATE SIGNED: 2-10-59

PHYSICIAN'S NAME (Type): R.C.Dodson — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 11, 1959
22c. NAME OF CEMETERY OR CREMATORY: Rosebank Cemetery
22d. LOCATION (City, town, or county) (State): Rising Sun, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson — ADDRESS: Rising Sun Md

24a. REC'D BY REGISTRAR — DATE: FEB 11 '59
24b. REGISTRAR'S SIGNATURE: Gilbert L. Hance

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1759

CERTIFICATE OF DEATH

01765
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East (Rural)
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl; Middle: Elizabeth; Lost: Dean

4. DATE OF DEATH: Month: Feb. Day: 13 Yeor: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14, 1894
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): worker
10b. KIND OF BUSINESS OR INDUSTRY: Fireworks Factory
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Luther R. Cutlip
14. MOTHER'S MAIDEN NAME: Maggie Ann Shue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 236-26-2446
17. INFORMANT: Edgar W. Dean — Address: North East (Rural) Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Right cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Cerebral Arteriosclerosis — 1 year
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertrophic osteo-arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Feb, 1959, to 13 Feb, 1959, that I last saw the deceased alive on 13 Feb, 1959, and thot deoth occurred at 1 A. M, fram the couses and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D.
ADDRESS (Street, city or town, state): North East, Md
DATE SIGNED: 13 Feb 59
PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Feb 13-1959
22c. NAME OF CEMETERY OR CREMATORY: Old Drew Church Cemetery
22d. LOCATION (City, town, or county) (State): Lewisburg West Va

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East, Md
24a. RECD BY REGISTRAR DATE: FEB 16 59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1760 — 01766 — Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × R. D. 2 Elkton
d. STREET ADDRESS: White Hall Farm
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Dill
4. DATE OF DEATH: Month: February — Day: 2, — Year: 1959
5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 4, 1904
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Norman George
14. MOTHER'S MAIDEN NAME: Annette Hollabaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clarence E. Dill, Address: Elkton, Md. R. D. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH:
592 ×
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chornic Nephritis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. C. Dodson M.D. — DATE SIGNED
EXAMINER'S NAME (Type): R. C. Dodson, M.D., — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 2/3/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/5/59
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cecil County Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1761 — 01767 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 HRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 ELKTON
d. STREET ADDRESS: UNION HOSPITAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

3. NAME OF DECEASED (Type or print): First — Middle — Last: Baby Boy Edwards
4. DATE OF DEATH: Month: Feb — Day: 10 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 10, 1959
9. AGE (In years last birthday): ____ yrs. IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours 2 Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALLARD L. EDWARDS
14. MOTHER'S MAIDEN NAME: MYRTLE JUNE CASTELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ALLARD L. EDWARDS — Address: ELKTON, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 10, 1959 to Feb 10, 1959, that I last saw the deceased alive on Feb 10, 1959, and that death occurred at 11:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Milford H. Sprecher M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 2/11/59

PHYSICIAN'S NAME (Type): MILFORD H. SPRECHER

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/12/59
22c. NAME OF CEMETERY OR CREMATORY: GILPIN MANOR MEM. PARK
22d. LOCATION (City, town, or county) (State): NR. ELKTON, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Pippin — ADDRESS: ELKTON, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2065261XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1774

CERTIFICATE OF DEATH

01768 Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside carparote limits, write RURAL and give nearest town): X Rising Sun Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First George — Middle Littleton — Last Ewing
4. DATE OF DEATH: Month Feb. — Day 12 — Year 195
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 25, 1875
9. AGE (In years lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter
11. BIRTHPLACE (State or foreign country): Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Amos Ewing
14. MOTHER'S MAIDEN NAME: Laura Ewing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-14-8902
INFORMANT: Mrs. Evan Job — Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-15- 1958, to 2-9- 1959, that I last saw the deceased alive on 2-9 1959, and that death occurred at 4 A M, fram the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D.
ADDRESS (Street, city or tawn, state): Rising Sun, Md.
DATE SIGNED: 2-13-59

PHYSICIAN'S NAME (Type): R.C. Dodson — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 15, 1959
22c. NAME OF CEMETERY OR CREMATORY: Rosebank Cem.
22d. LOCATION (City, town, or county): Calvert (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson — ADDRESS: Rising Sun Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01769

1775

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 10 yrs. 9 mo.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 940 Randolph St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle C. Last FARLEY JR.

4. DATE OF DEATH: Month February Day 27 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-27-09

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Engineer

10b. KIND OF BUSINESS OR INDUSTRY: General Elec. Co.

11. BIRTHPLACE (State or foreign country): Alabama

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John C. Farley, Sr.

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, lower lobes, — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
420.0
DUE TO (b): unresolved Arteriosclerotic heart disease, severe — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 27, 19 48, to February 27, 19 59, that I last saw the deceased alive on February 27, 19 59 and that death occurred at 6:15 a.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): V.A.Hospital, Perry Point, Md. — DATE SIGNED: 3-2-59

PHYSICIAN'S NAME (Type): S. P. LACERVA — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 3/3/1959

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: MAR 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1776 **CERTIFICATE OF DEATH** 01770

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cecilton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ROBERT Middle Last GARRISON

4. DATE OF DEATH Month Feb. Day 6, Year 1959

5. SEX Male

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH August, 14, 1909

9. AGE (In years last birthday) 49 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Construction

10b. KIND OF BUSINESS OR INDUSTRY LABOR

11. BIRTHPLACE (State or foreign country) Cecilton, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Garrison

14. MOTHER'S MAIDEN NAME Bessie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 222-07-0816

17. INFORMANT Address Bessie Garrison, Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH 3 days

157X

DUE TO (b) Carcinoma of Pancreas — 8 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 10, 1958 to Feb 6, 1959, that I last saw the deceased alive on Feb 6, 1959, and that death occurred at 7.00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wallace Obenshain M.D. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 6 Feb 59

PHYSICIAN'S NAME (Type) Wallace Obenshain, Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Feb. 11, 1959

22c. NAME OF CEMETERY OR CREMATORY Cecilton Col. Cemetery

22d. LOCATION (City, town, or county) (State) Cecilton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Fellows Millington Md.

24a. REC'D BY REGISTRAR DATE FEB 13 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

Item 20 Film 239 3-10-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01771

1777

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Route 7
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X R D 1 , Elkton, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: F. — Last: Grayson

4. DATE OF DEATH: Month: February — Day: 28 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Aug. 23, 1923

9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: Fireworks

11. BIRTHPLACE (State or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Gillman B. Grayson

14. MOTHER'S MAIDEN NAME: Frances MaMafey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W W II

16. SOCIAL SECURITY NO.: 169-18-1935

17. INFORMANT — Address: Willie Grayson, R.D. 1, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 812 X — Compound fracture of occipital bone,
DUE TO (b): fracture 4th cerebral vertabrae,
DUE TO (c): crsuhed chest and other injuries extreme

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was hit by a car

20c. TIME OF INJURY: Hour: 2:30 a. m. p. m. — Month, Day, Year: 2-28-59 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 7

20f. (City or town): Elkton, R.D., — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R L Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): R. C. Dodson, M.D.

DATE SIGNED: March 2, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/3/59

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland

24a. REC'D BY REGISTRAR — DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMC. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME BM 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01772

1762 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2/Elkton
d. STREET ADDRESS: 1 324 North Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Floren ce — Middle: L. — Last: Hayter

4. DATE OF DEATH: Month: February — Day: 9 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 24, 1882

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George H. Maxwell

14. MOTHER'S MAIDEN NAME: Laura Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ------

17. INFORMANT: Mrs. Harry Biddle, Address: Elktonm Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio Vascular failure — INTERVAL BETWEEN ONSET AND DEATH: 15 min

443 ×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): cerebral & gastrointestinal hemorrhage — 1 1/2 mos

DUE TO (c): Hypertensive cardio vascular disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): generalized arterio sclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-29, 19 58, to 2-9, 19 59, that I last saw the deceased alive on 2-9, 19 59, and that death occurred at 4.40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Luis M. Cuza M.D. — ADDRESS (Street, city or town, state): Cecil Avenue, North East, Md. — DATE SIGNED: Feb 10, 1959

PHYSICIAN'S NAME (Type): Luis M. Cuza

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 12/59

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: FEB 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1778

CERTIFICATE OF DEATH

Reg. Dist. No. 11773 96

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4yrs.4mo.17days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington 46X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital
d. STREET ADDRESS: Adams
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

50

3. NAME OF DECEASED (Type or print): First ROBERT Middle G. Last HOLMES
4. DATE OF DEATH: Month February Day 16 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-27-98
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY: Not ascertainable
11. BIRTHPLACE (State or foreign country): Seattle, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not ascertainable
14. MOTHER'S MAIDEN NAME: Margaret (?)Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Peacetime
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

1

2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
490X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized, severe
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 30 19 54, to February 16 1959, that I last saw the deceased alive on ... and that death occurred at 7:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.
DATE SIGNED: 2-18-59
PHYSICIAN'S NAME (Type): S. P. LACERVA
Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 2/25/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: FEB 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1779

Reg. Dist. No. 01774

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Richmond Hill

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville, Rural
d. STREET ADDRESS: Richmond Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Arthur — Last: Hornbarger

4. DATE OF DEATH: Month: 2 — Day: 2 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-7- 1912

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Land Lord

10b. KIND OF BUSINESS OR INDUSTRY: Appts.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Arthur W. Hornbarger

14. MOTHER'S MAIDEN NAME: Nellie Bines. ~~Bines~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 717-07-5572

INFORMANT: .Thelma Hornbarger, Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Carcinoma
163X
DUE TO (b): Upper Lobe Rt. Lung —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1958 to Feb 2 1959 that I last saw the deceased alive on Feb-2 1959, and that death occurred at 8.50 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson M.D.
ADDRESS (Street, city or town, state): Port Deposit
DATE SIGNED: 2-3-59

PHYSICIAN'S NAME (Type): Clarence I. Benson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-5-1959
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Sons
ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

Item 20 Film 239 3-6-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01775

Reg. Dist. No. 96

FOR STATE HEALTH DEPT.

1780

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4yrs.6mo.27days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2109 Lincoln Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03X-2

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	W.	JAMES JR	February	19	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		10-29-31	27 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Never Worked		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. James Sr.	Mercedes Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes — Korean	Unknown	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Exposure — INTERVAL BETWEEN ONSET AND DEATH

932.8

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was found lying in the woods near the fence of VA Reservation

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
o. m. / p. m. — 19		Woods	Cecil Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

(Exposure)

ACTUAL SIGNATURE: R. C. DODSON M.D.

EXAMINER'S NAME (Type): R. C. Dodson

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 2-20-59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	2/21/59	Oaklawn	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Pennington & Son, Havre de Grace, Md.	FEB 26 '59	Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01776

1781

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1125-5th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ISAAC — Middle: (NMI) — Last: JOHNSON

4. DATE OF DEATH: Month: Feb. — Day: 7 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 5, 1886

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian, Retired

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Fauquier Co., Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edmund Johnson

14. MOTHER'S MAIDEN NAME: Molly Minor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 5/7/17 3-8-19

16. SOCIAL SECURITY NO.: 579-42-4561

17. INFORMANT: Hospital Records, VAH, Perry Point, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Encephalomalacia of fronto-parietal area right due to arteriosclerosis, severe — INTERVAL BETWEEN ONSET AND DEATH: Unk.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral thrombosis due to arteriosclerosis of basilar artery — Unk.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 4, 1959, to Feb. 7, 1959, that I last saw the deceased [illegible], and that death occurred at 1:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. S. Ells, M.D. — ADDRESS (Street, city or town, state): V. A. Hospital, Perry Point, Md. — DATE SIGNED: 2-7-59

PHYSICIAN'S NAME (Type): E. S. ELLS, M.D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2/9/59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

22d. LOCATION (City, town, or county) (State): Ft. Myers, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: PENNINGTON & SONS — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: FEB 17 '59

24b. REGISTRAR'S SIGNATURE: Clinton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Perry Point ... Washington

Veterans Administration Hospital

Male Negro ... Jan. 5, 1896

... Lancaster Co., Virginia

Edmund Johnson ... Polly ...

... Veterans Hospital, Perry Point, Md.

... arteriosclerosis ...

I hereby certify that I attended the deceased from ... 19... to ..., 1953 ...

... Perry Point, Md.

... Quantico National Cem. ... Triangle, Virginia

... Md.

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01777

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington 46 X-3
d. STREET ADDRESS: 727 N. Dupont St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: L. — Last: Jones Jr.

4. DATE OF DEATH: Month: February — Day: 22 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11-21-25

9. AGE (In years last birthday): 33 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Not Ascertainable

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest L. Jones Sr.

14. MOTHER'S MAIDEN NAME: Eva M. Laurey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 221 14 5386

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema and congestion, bilateral, severe — INTERVAL BETWEEN ONSET AND DEATH: 4 to 5 hours
353.1
DUE TO (b): Chronic Brain Syndrome associated with brain trauma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): left side Grand Mal (Clinical) — Unknown Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 2-22-59

EXAMINER'S NAME (Type): R. C. DODSON, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-22-59

22c. NAME OF CEMETERY OR CREMATORY: Beverly National Cemetery

22d. LOCATION (City, town, or county) (State): Beverly, N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1783

Reg. Dist. No. 01778

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Graybeal Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun
d. STREET ADDRESS: Mount Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip; Middle: Rowland; Last: Kyle

4. DATE OF DEATH: Month: February; Day: 18; Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1885

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Creamery

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Kyle

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-8928

INFORMANT: Mrs. Claude Yates
Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the left side of face and
DUE TO
(b): eye and skull
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

190.8

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19__, to 2-16-59, 19__, that I last saw the deceased alive on 2-16-59, 19__, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C.Dodson M.D.
ADDRESS (Street, city or town, state): Rising Sun, Md.
DATE SIGNED: 2-20-59

PHYSICIAN'S NAME (Type): R.C.Dodson
Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 21, '59
22c. NAME OF CEMETERY OR CREMATORY: Brookview
22d. LOCATION (City, town, or county) (State): Rising Sun, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson
ADDRESS: Rising Sun Md

24a. REC'D BY REGISTRAR DATE: FEB 24 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1763 Item 9 FilmG239 3-12-59 et

Reg. Dist. No. 01779

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 24 hurs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N.J.
b. COUNTY: Burlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Burlington
d. STREET ADDRESS: 624 Washington Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: ; Last: Manzi

4. DATE OF DEATH: Month: 2; Day: 26; Year: 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 9 6-10-1903 1911

9. AGE (In years last birthday): 47 48 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Hair cutting

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Manzi

14. MOTHER'S MAIDEN NAME: Mary Napoli

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Manzi, 624 Washington Ave Burlington, N.J.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Torn Bowel with shock
816 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran his car under a truck

20c. TIME OF INJURY: Hour 8.15 a.m. m.; Month, Day, Year: 2 25 19 59

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Roue 40

20f. (City or town): Elkton (County): Cecil (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): R.C.Dodson

DATE SIGNED: 2-27-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 2, 1959

22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

22d. LOCATION (City, town, or county) (State): Burlington, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks

ADDRESS: Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1784

Reg. Dist. No. 01780

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, Rural
c. LENGTH OF STAY IN 1b: 50 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Aikin

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence befare admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): X Perryville, Rural
d. STREET ADDRESS: Aikin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Howard — Last: McGuire

4. DATE OF DEATH: Month: Feb. — Day: 17, — Year: 1959

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1883

9. AGE (In years last birthday): 7 5 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason

10b. KIND OF BUSINESS OR INDUSTRY: Penna. Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McGuire

14. MOTHER'S MAIDEN NAME: Emma Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 717-07-5276

INFORMANT: James H. McGuire — Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
DUE TO (b): Hypertensive Cardio Vascular disease — 5 yrs.
DUE TO (c): Mild Stroke — 3 yr.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Month, Day, Year — Haur o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Nat while at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1954, to Feb 17, 1959, that I last saw the deceased alive an Feb 17 1959, and that death accurred at 2:45 P.M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: G.H. Richards Jr. M.D. — ADDRESS (Street, city or town, state): R.F.D. #3 Port Deposit, Md — DATE SIGNED: 2-17-59

PHYSICIAN'S NAME (Type): G.H. Richards Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/19/1959

22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

22d. LOCATION (City, town, or county) (State): Port Deposit, R.F.D., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Sons — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar ta burial, cremation, ar removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1764

Reg. Dist. No. 11781

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kentmore Park, Rural Kennedyville 14X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IVAR — Middle — Last MEURLING

4. DATE OF DEATH: Month February — Day 12, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January, 6, 1880

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Machine

11. BIRTHPLACE (State or foreign country): Sweden

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edgar Meurling

14. MOTHER'S MAIDEN NAME: Josephine Lindebled

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Mildred Meurling, Kennedyville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b): Nephrosclerosis — yeas
DUE TO (c):

446X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): urinary retention due to prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 9, 19 59, to Feb 12, 19 59, that I last saw the deceased alive on Feb 12, 19 59, and that death occurred at 3 00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 13 Feb 59

PHYSICIAN'S NAME (Type): WALLACE OBENSHAIN — CECILTON, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 15, 1959

22c. NAME OF CEMETERY OR CREMATORY: Crumpton Cem.

22d. LOCATION (City, town, or county) (State): Crumpton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellow — ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR — DATE: FEB 18 '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 18, Film 282, 3/13/61 - AMS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1785

01782

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 mo. 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 211 Calvert
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2212.2

50

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle (NMI) — Last MILES

4. DATE OF DEATH: Month February — Day 16 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-6-93

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Tabb Miles (Deceased)

14. MOTHER'S MAIDEN NAME: Lucy Brown (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 219 05 3335

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchogenic, anaplastic, Carcinoma ~~of pancreas with wide spread~~ with metastasis to bone, lymph nodes, stomach, liver, pancreas and left kidney

DUE TO (b): ~~Portal veins thrombosis secondary to above~~

DUE TO (c): Bronchopneumonia, bilateral, unresolved

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 months unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

2

21. I certify that ☒ VA attended the deceased from November 10, 1958, to February 16, 1959, that I last saw the deceased alive on xxxxxxxxxxxxxxxxxxxx 19xxxxx and that death occurred at 12:40 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md.

DATE SIGNED: 2-17-59

ACTUAL SIGNATURE: Bernard S Linn M.D.

PHYSICIAN'S NAME (Type): BERNARD S. LINN, M.D. Surgical Officer of the Day

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-19-59

22c. NAME OF CEMETERY OR CREMATORY: Crisfield

22d. LOCATION (City, town, or county) (State): Crisfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wharton-Savage Fun. Home, New Church, Va.

24a. REC'D BY REGISTRAR — DATE: FEB 20 '59

24b. REGISTRAR'S SIGNATURE: Clifford L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1786

CERTIFICATE OF DEATH

Reg. Dist. No. 11783

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Earleville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Earleville Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE — Middle R. — Last MOFFETT

4. DATE OF DEATH: Month February — Day 24, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May, 8,1875

9. AGE (In years lost birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Moffett

14. MOTHER'S MAIDEN NAME: Elizabeth Grady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-36-8937A

17. INFORMANT: William Moffett, — Address: Massey, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral thrombosis — 3 days
DUE TO
(c) Cerebral arteriosclerosis. — years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): far advanced senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1958, to Feb 24, 1959, that I last saw the deceased alive on 24 Feb, 1959, and that death occurred at 3:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain, M.D. M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 26 Feb 59

PHYSICIAN'S NAME (Type): Wallace G. Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 27, 1959

22c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cem.

22d. LOCATION (City, town, or county) (State): Warwick, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward F. Collins — ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE MAR 2 '59

24b. REGISTRAR'S SIGNATURE: Cecilia S. Keene

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01784

1787 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 127 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 14 Holly Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER — Middle J. — Last MURPHY

4. DATE OF DEATH: Month 2 — Day 14 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-97

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: PETER MURPHY

14. MOTHER'S MAIDEN NAME: NORA DISKEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT — Address: HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1. CORONARY ARTERIOSCLEROSIS (MARKED) WITH CONGESTIVE — INTERVAL BETWEEN ONSET AND DEATH: Over 2 Yrs.
420.1
DUE TO: HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): 2. CEREBRAL ARTERIOSCLEROSIS WITH CEREBRAL ATROPHY — Over 2 Yrs.
DUE TO: AND SECONDARY RIGHT HEMIPLEGIA
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral Bronchopneumonia

19. WAS AUTOPSY PEREORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: VA

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-9-58, 19____, to 2-14-59, 19XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX, and that death occurred at 7:50P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. C. Grasberger M.D.
ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md.
DATE SIGNED: 2-15-59

PHYSICIAN'S NAME (Type): J. C. GRASBERGER, M.D. Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-15-59
22c. NAME OF CEMETERY OR CREMATORY: Long Island National
22d. LOCATION (City, town, or county) (State): Farmingdale, L.I., N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Cunningham Son
ADDRESS: Havre De Grace, Md.

24a. REC'D BY REGISTRAR DATE: FEB 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1765

CERTIFICATE OF DEATH

01785

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 ELKTON
d. STREET ADDRESS: 102 Mitchell ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Ruth; Middle: ; Last: Ritter

4. DATE OF DEATH: Month: Feb.; Day: 24; Year: 1959

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/23/58

9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months: 2; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mr. Billie Ritter

14. MOTHER'S MAIDEN NAME: Friedhilde Kormelia Schuhmacher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Viral Gastro enteritis
571.0
DUE TO
(b): & Bronchitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mild Dehydration and Prematurity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour: o. m. / p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 3, 1959 to Feb 23, 1959, that I last saw the deceased alive on Feb 23, 1959, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry A. Sunnell M.D.
ADDRESS (Street, city or town, state): 245 E. High Street
DATE SIGNED: 2-24-59
PHYSICIAN'S NAME (Type): Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 28/59
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) (State): Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE

2065356XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1788

CERTIFICATE OF DEATH

Reg. Dist. No. 01786

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN
c. LENGTH OF STAY IN 1b: 76 YRS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x RISING SUN

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:
d. STREET ADDRESS: E. MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AMY Middle VIRGINIA Last ROBINSON
4. DATE OF DEATH: Month FEB. Day 18 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 27, 1912
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOK KEEPER
10b. KIND OF BUSINESS OR INDUSTRY: FEED WAREHOUSE
11. BIRTHPLACE (State or foreign country): RISING SUN, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS A. CROTHERS
14. MOTHER'S MAIDEN NAME: VIOLA M. LYNCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 164-10-6366
17. INFORMANT: CLARA LOVE Address: CONOWINGO, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Widespread adeno carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
199.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/1 19 58, to 2/18 19 59, that I last saw the deceased alive on 2/18 19 59, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. ADDRESS (Street, city or town, state): Rising Sun, Md DATE SIGNED: 2/19/59
PHYSICIAN'S NAME (Type): N

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/21/59
22c. NAME OF CEMETERY OR CREMATORY: FRIENDS
22d. LOCATION (City, town, or county) (State): CALVERT MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ralph M Reed, Rising Sun, Md
24a. REC'D BY REGISTRAR DATE: FEB 20 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1766

CERTIFICATE OF DEATH

01787

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b: 4days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma — Middle T — Last Rutter

4. DATE OF DEATH: Month 2 — Day 4 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 23, 1876

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk Ret. 15 yrs

10b. KIND OF BUSINESS OR INDUSTRY: Atlas Powder Co

11. BIRTHPLACE (State or foreign country): North East, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. Alexander Rutter

14. MOTHER'S MAIDEN NAME: Rebecca Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 221-03-0073

17. INFORMANT: Robert C. Reeder Jr. — Address: Westfield 339 Tuttle Parkway N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gastric Hemorrhage and Shock.

4621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO (b): Hemorrhage from ruptured Esophageal Varices

DUE TO (c): Cardio Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 19 59, to Feb 4, 19 59, that I last saw the deceased alive on Feb. 4, 1959, 19 , and that death occurred at 9:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Arthur Cantwell M.D. — ADDRESS (Street, city or town, state): North East Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): H. Arthur Cantwell, M.D. — North East, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/7/59

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Cecil, Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph A. Grant — ADDRESS: North East, Md

24a. REC'D BY REGISTRAR DATE: FEB 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1767 — 01788 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle L. — Last SHELTON

4. DATE OF DEATH: Month February — Day 27, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 23, 1877

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Shelton

14. MOTHER'S MAIDEN NAME: Sarah L. Registar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-22-3583

17. INFORMANT Address: Mrs. Elizabeth Shelton, Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion acute — INTERVAL BETWEEN ONSET AND DEATH: 4 days

420.1

DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b): Coronary artery disesae. — years.

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral inguinal herhiae.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 25, 1959, to Feb 27, 1959, that I last saw the deceased alive an Feb 27, 1959, and that death occurred at 10:05 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obensnain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 2 Mar 59

PHYSICIAN'S NAME (Type): Wallace Obensnain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 2, 1959

22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery

22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington Md

24a. REC'D BY REGISTRAR DATE MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1789 **CERTIFICATE OF DEATH** 01789

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural

LENGTH OF STAY (In this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Md. Rural

STREET ADDRESS (If rural give location): Rout 276

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Simcoe

4. DATE OF DEATH: (Month) Feb. (Day) 1 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Single	March 30, 1883	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Laborer	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamen Simcoe	Mary Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	220-18-7236A	R.B. Marshall, Port Deposit, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 Dy

ANTECEDENT CAUSE(S) DUE TO (B) Cirrhosis alcoholic Heart disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 19 59, to 2/1, 19 59, that I last saw the deceased alive on 2/1, 19 59, and that death occurred at 7:45 M, from the causes and on the date stated above.

SIGNATURE Frank H. MacComas M.D. **ADDRESS** (Street, city, town, state) Wm. de Grace Md **DATE SIGNED** 2/3/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-4-1959	West Nottingham	Port Deposit, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
FEB 5 59	Arthur L. Krauss	Lee Patterson & Son	Perryville, Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1790 **CERTIFICATE OF DEATH** 01790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural c. LENGTH OF STAY IN 1b: Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun Rural
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. STREET ADDRESS f. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First: Ella	Middle: McCall	Last: Simmers	4. DATE OF DEATH	Month: February	Day: 26	Year: 1959			
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: June 1872	9. AGE (In years last birthday): 86 yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Anderson McCall		14. MOTHER'S MAIDEN NAME: Hettie Lackland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Robert Simmers Address: Rising Sun, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cronic Myocardicjs — INTERVAL BETWEEN ONSET AND DEATH

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): General Artterio Sclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from May 1958, 19____, to Feb 25, 19 59, that I last saw the deceased alive on Feb 25, 19 59, and that death occurred at 5.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D. ADDRESS (Street, city or town, state): Rising Sun, Maryland DATE SIGNED:

PHYSICIAN'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: March 1-59	22c. NAME OF CEMETERY OR CREMATORY: Ebenezer	22d. LOCATION (City, town, or county) (State): Rising Sun, cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Frank	ADDRESS: North East Md	24a. REC'D BY REGISTRAR DATE MAR 2 '59	24b. REGISTRAR'S SIGNATURE: Orrin S. Knauf	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01791

CERTIFICATE OF DEATH

Reg. Dist. No. 1768

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 6 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rd #3 Elkton.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Virginia Middle: Christine Last: Smith

4. DATE OF DEATH: Month: 2 Day: 25 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-25-59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: Hours: 6 Min.: 00
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Elkton Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Lee Smith

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Wyant.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Robert Lee Smith Rd#3 Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiorascular failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Respiratory failure — 5 hrs.

DUE TO (c): Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-25, 1959, to 2-25, 1959, that I last saw the deceased alive on 2-25 1959, and that death occurred at 5:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): North East, Md.

DATE SIGNED:

PHYSICIAN'S NAME (Type): LUIS M. CUZA

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-26-59

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton Md

23. FUNERAL DIRECTOR'S SIGNATURE: N. Walter DuBois Jr.

ADDRESS: Elkton

24a. REC'D BY REGISTRAR DATE: MAR 2 '59

24b. REGISTRAR'S SIGNATURE: Clinton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5S

2065202 X V 0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1769

CERTIFICATE OF DEATH

01792
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 10 Min.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Union Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City,
d. STREET ADDRESS: Lewis Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle ALBERT — Lost STAPP

4. DATE OF DEATH: Month February — Day 20 — Year 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 30, 1893
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maint. Supt.
10b. KIND OF BUSINESS OR INDUSTRY: C. and D. Canal
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Stapp
14. MOTHER'S MAIDEN NAME: Mary Krastel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 169-20-1586
17. INFORMANT: Mrs. Mildred R. Stapp — Address: Ches. City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Oh Hour
DUE TO (b): Chronic myocarditis — one Year
DUE TO (c):
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 14, 19 58 to Feb 20, 19 59, that I last saw the deceased alive on Febru 20, 19 59, and that death occurred at 11 46 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry V. Davis M.D. — ADDRESS (Street, city or town, state): Chesapeake City Md. — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/24/1959
22c. NAME OF CEMETERY OR CREMATORY: St. Roses Cemetery
22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pippin Funeral Home — ADDRESS: Donald M. Pippin Elkton, Md.
24a. REC'D BY REGISTRAR DATE: FEB 24 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1791 CERTIFICATE OF DEATH

01793

Reg. Dist. No. 97

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 10 minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 17 Gallagher Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth; Middle: Ellen; Last: Vasco

4. DATE OF DEATH: Month: February; Day: 14; Year: 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 February 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months; Days; Hours; Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joseph Anthony Vasco

14. MOTHER'S MAIDEN NAME: Barbara Jane Kahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURE SEPARATION OF PLACENTA — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
761.0
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 February, 1959, to 14 February 1959, that I last saw the deceased alive on 14 February, 1959, and that death occurred at 9:15 AM from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Richard B. Speaker M.D.

PHYSICIAN'S NAME (Type) RICHARD B. SPEAKER LCDR MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/19/59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son

ADDRESS: LEE A. PATTERSON & SON PERRYVILLE, MD.

24a. REC'D BY REGISTRAR DATE: FEB 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

2051334XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1792

CERTIFICATE OF DEATH

01794 96
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 8 mo. 12 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA — b. COUNTY: CHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXFORD 75 x-3
d. STREET ADDRESS: 27 North 4th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle D. — Last WALKER

4. DATE OF DEATH: Month February — Day 23, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Army Officer
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANKLIN WALKER
14. MOTHER'S MAIDEN NAME: LOUISA FITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Hospital Records, VA Hospital, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 month
491 X
DUE TO
(b)
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1. Generalized marked arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year / Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 6, 1958 to February 23, 1959 that I last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 2:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Burke Sutt M.D.
ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md.
DATE SIGNED: 2-23-59
PHYSICIAN'S NAME (Type): R. BURKE SUTT, M.D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2-24-59
22c. NAME OF CEMETERY OR CREMATORY: New London
22d. LOCATION (City, town, or county) (State): New London, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Penington & Son
ADDRESS: Havre DeGrace, Md.
24a. REC'D BY REGISTRAR DATE: FEB 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1770

Reg. Dist. No. 01795

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elk Mills
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Essie — Middle R. — Last Watts

4. DATE OF DEATH: Month February — Day 13 — Year 1959

5. SEX: F

6. COLOR OR RACE: Wh.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 9, 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Havre De Grace, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: No Information

14. MOTHER'S MAIDEN NAME: Margaret No Information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Helen G. Wiley — Address: 219 W. Park Place Newark, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH: unknown

443 X

DUE TO: cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteoporosis of spine with collapse of lumbar vertebrae

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 8, 19 59 to Feb. 13, 19 59 that I last saw the deceased alive on Feb. 13, 19 59, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main Street — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-17-1959
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.
22d. LOCATION (City, town, or county) (State): R. D. Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Donald M. Pippin — ADDRESS: Elkton, Md.
W. H. Pippin Funeral Home

24a. REC'D BY REGISTRAR DATE: FEB 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1771 — Reg. Dist. No. 01796

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: UNION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELKTON RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Diane — Middle: E — Last: White

4. DATE OF DEATH: Month: Feb — Day: 9 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 3-31-1955

9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: RICHARD E WHITE

14. MOTHER'S MAIDEN NAME: POLLY ANN SPENCE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Richard E White Elkton RD Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
590X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Upper Resp. Infection — 3 wks
DUE TO
(c): Acute Nephritis — ? wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiac Failure

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): None

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m.; 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 Feb, 1959, to 9 Feb, 1959, that I last saw the deceased alive on 9 Feb, 1959, and that death occurred at 9:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George J Kreis Jr. M.D. — ADDRESS (Street, city or town, state): Elkton, Md — DATE SIGNED:

PHYSICIAN'S NAME (Type): George J. Kreis, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-12-1959

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East Cecil Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph R Grant North East Md

24a. REC'D BY REGISTRAR — DATE: FEB 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1793 CERTIFICATE OF DEATH

Reg. Dist. No. 01797

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 127 N. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): X Port Deposit
d. STREET ADDRESS: 127 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle Wesley — Last Williams

4. DATE OF DEATH: Month Feb. — Day 13 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 17, 1876

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire Fighter

10b. KIND OF BUSINESS OR INDUSTRY: U S V. Hospital.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W. Williams

14. MOTHER'S MAIDEN NAME: Amelia Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-6226

INFORMANT: Minnie B. Williams, Address: Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	5 days
DUE TO (b)	Paralysis left side and blind — Cerebral Sclerosis	4 yrs
DUE TO (c)	Arterio-Sclerosis — Hypertension	7 yrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb-8, 1959, to Feb 12, 1959, that I last saw the deceased alive on Feb-12-, 1959, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson M.D. — ADDRESS (Street, city or town, state): Port Deposit — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): Clarence I. Benson M.D. — Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-15-1959

22c. NAME OF CEMETERY OR CREMATORY: Hopewell

22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Sons — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58